PRINTED: 09/22/2017
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN4711 | A. BUILDING: _____ B. WING _____ | 09/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINDRED HEALTH AND REHABILITATION-NOF | 3300 BROADWAY NE KNOXVILLE, TN 37917 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>A licensure survey and complaint investigations (#41156, #42190, #42195, #40960, #42256, #42279, #41437) were conducted on 9/11/17 through 9/13/17, at Kindred Health and Rehab-Northhaven. No health deficiencies were cited in relation to the complaints under Chapter 1200-08-06, Standards for Nursing Homes. | N 000 | | |

Division of Health Care Facilities

| REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Willeen R Knapp | Executive Director | 10/5/2017 |